(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) CMS does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

[50 FR 12741, Mar. 29, 1985, as amended at 53 FR 38527, Sept. 30, 1988; 57 FR 39821, Sept. 1, 1992; 60 FR 63188, Dec. 8, 1995; 65 FR 18537, Apr. 7, 2000]

### § 412.52 Reporting and recordkeeping requirements.

All hospitals participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

[50 FR 12741, Mar. 29, 1985, as amended at 51 FR 34793, Sept. 30, 1986; 57 FR 39821, Sept. 1, 1992]

## Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

### § 412.60 DRG classification and weighting factors.

(a) *Diagnosis-related groups.* CMS establishs a classification of inpatient hospital discharges by Diagnosis-Related Groups (DRGs).

(b) *DRG weighting factors.* CMS assigns, for each DRG, an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(c) *Assignment of discharges to DRGs.* CMS establishs a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG based on essential data abstracted from the inpatient bill for that discharge.

(1) The classification of a particular discharge is based, as appropriate, on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

(2) Each discharge is assigned to only one DRG (related, except as provided in paragraph (c)(3) of this section, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

(3) When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill is returned to the hospital for validation and reverification. CMS's DRG classification system provides a DRG, and an appropriate weighting factor, for the group of cases for which the unrelated diagnosis and procedure are confirmed.

(d) *Review of DRG assignment.* (1) A hospital has 60 days after the date of the notice of the initial assignment of a discharge to a DRG to request a review of that assignment. The hospital may submit additional information as a part of its request.

(2) The intermediary reviews the hospital's request and any additional information and decides whether a change in the DRG assignment is appropriate. If the intermediary decides that a higher-weighted DRG should be assigned, the case will be reviewed by the appropriate QIO as specified in § 466.71(c)(2) of this chapter.

(3) Following the 60-day period described in paragraph (d)(1) of this section, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

(e) *Revision of DRG classification and weighting factors.* Beginning with discharges in fiscal year 1988, CMS adjusts the classifications and weighting factors established under paragraphs (a) and (b) of this section at least annually to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources.

[50 FR 12741, Mar. 29, 1985, as amended at 52 FR 33057, Sept. 1, 1987; 57 FR 39821, Sept. 1, 1992; 59 FR 45397, Sept. 1, 1994]